

Patient Referral Form



Pediatric Cardiology
Medical Group
- East Bay

An affiliate of
Packard Children's
Health Alliance

Please indicate the family's preferred office and fax this form and pertinent notes to the designated fax number:

	Fax #		Fax #
<input type="radio"/> Brentwood	925-295-1704	<input type="radio"/> Napa	707-863-8193
<input type="radio"/> Emeryville	510-587-9624	<input type="radio"/> Oakland	510-428-3381
<input type="radio"/> Fairfield	707-863-8193	<input type="radio"/> Pleasanton	925-295-1704
<input type="radio"/> Larkspur	510-587-9624	<input type="radio"/> Sonoma	925-295-1704
<input type="radio"/> Modesto	925-295-1704	<input type="radio"/> Walnut Creek	925-295-1704

PATIENT INFORMATION

Patient's First Name _____ Last Name _____

DOB ____/____/____ Gender ☐ Female ☐ Male

Parent/Guardian Name _____ Relationship _____

Address _____

Daytime Phone (_____) _____ Alternate Phone (_____) _____

Interpreter needed? ☐ No ☐ Yes If so, what Language? _____

INSURANCE INFORMATION

Health Plan _____ Authorization # _____

Group # _____ Member ID _____

REFERRING MD CONTACT INFORMATION

Referring MD _____ Best way to reach me is by ☐ Phone ☐ Fax ☐ Pager

Back Line Phone (_____) _____ Fax (_____) _____

Office Name/Location _____ Pager _____

MEDICAL INFORMATION

Diagnosis/Reason for referral _____

Is this an urgent referral? ☐ No ☐ Yes

The following are considered to be urgent:

- infants under three months of age (please call us!)
- syncope with exercise
- any concern about cardiac risk
- any other physician or family concerns; please describe below:

Previous visit(s) to PCMG and/or Healthy Hearts for this problem?

☐ No ☐ Yes

Date of Referral: _____

ATTACHMENTS

Please note: Sending this information helps us give your patient the most effective care.

- ☐ Recent Office Notes
- ☐ Growth Chart
- ☐ Pertinent Lab Studies

Please call if you would like to speak with the consulting physician prior to the appointment.